King County

Department of
Community and Human Services

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FINAL PROCUREMENT PLAN
Veterans and Human Services Levy: 2.5(b)
Forensic Intensive Supportive Housing Project

1. Goal (Overarching Investment Strategy)

To end homelessness through outreach, prevention, permanent supportive housing and employment.

2. Objective (Specific Investment Strategy)

To enhance capacity of the King County CJI to locate, secure and provide the supportive housing options needed by ex-offenders who are homeless and re-entering the community from jails throughout King County.

3. Population Focus

The project seeks to secure permanent supportive housing for vulnerable adults with histories of long-term homelessness and involvement with the King County Criminal Justice System or the Washington State Veterans Reintegration Services (VRS) project, a joint project between the Washington State Department of Veterans Affairs and the King County Veterans Program. The first target population consists of homeless veterans and non-veterans with mental illness who are involved with a mental health court in King County and subsequently found incompetent due to severe psychiatric impairment. Thirty-five such cases were dismissed by the Seattle Municipal Mental Health Court alone during first quarter 2008. Of these, 14 (40%) were currently enrolled in outpatient services in King County and another 14 (40%) were previously enrolled. Over half of the cases had at least one Involuntary Treatment Act hospitalization. Other mental health courts include King County District Mental Health Court and Auburn Municipal Mental Health Court, and an additional or expanded mental health court beginning in 2009 as funded via the Mental Illness and Drug Dependency sales tax.

The second target population consists of homeless veterans identified by the VRS project who are incarcerated in any jail within King County, impaired by mental illness and psychological trauma, and are in need of long-term or permanent supportive housing. Many of these individuals will have co-occurring substance abuse disorders. Some individuals will be involved with and supervised by the State Department of Corrections (DOC). For the current King County CJI projects, 30 percent of the funds are for services to veterans and 70 percent are for others.

These target populations represent some of our more vulnerable citizens. Perhaps the most vulnerable are the veterans and non-veterans who are found not legally competent (typically because the defendant is unable to assist his/her attorney in their defense or is unable to understand the nature of the criminal court proceedings) and who do not qualify under the statute for a referral to Western

State Hospital (WSH) for competency restoration or civil commitment evaluation. In such situations, the case is dismissed and the court subsequently has no jurisdiction over the individual. As a result, the individual is released into the community often having no services, housing, or supports. These individuals typically commit other nuisance crimes and recycle through local jails at significant cost to the criminal justice system and with little opportunity for improvement in their lives.

Positive outcomes for the target populations are often hindered by the lack of permanent and/or long-term supportive housing due to the defendants' criminal offenses and lack of rental history. Outcomes are also hindered by the challenges experienced by landlords in working with these populations and the absence of interim step-down programs to continue the progress made by them. Without necessary supportive services, these populations face many barriers to obtain housing or retain existing housing. A result is that clients often drop out of services or are unable to develop linkage to services, recycling through the local jail and court systems, incurring costly judicial, prosecutorial, public defense, jail and forensic evaluation services. Adding housing and comprehensive wraparound services to prevent criminal justice involvement will yield significant outcomes, including reduced recidivism.

The Forensic Intensive Supportive Housing (FISH) Project will serve up to 60 homeless, mentally ill veterans and non-veterans over a three year period. The project is described in detail in the Program Strategy Description section.

4. Need or Risk Information

Local and national data highlight the powerful links between mental illness/co-occurring disorders, jail and homelessness.

- *Homelessness Linked to Jail:*
  Among individuals enrolled in the King County's mental health system, those who are homeless are four times more likely to be jailed than those with housing.

- *Homelessness among Veterans*:
  According to the King County Continuum of Care Plan, "Veterans constitute the single largest group within the homeless population, estimated for King County (as well as nationally) at 40% of the homeless." Data published by the Washington State Department of Veterans Affairs estimated that 2,500 homeless veterans live in the Seattle area, and there are approximately 3,300 homeless in King County (including Seattle).

- *Mental Illness and Substance Abuse Among the Homeless*
  Nearly half of the 5,963 homeless individuals counted in shelters or transitional housing during the 2006 One Night Count had problems with mental illness or substance abuse. Homelessness is the norm in King County's jails; 50% of all inmates utilizing Jail Health Services reported they were homeless; 25% reported living in shelters or on the street.
  Recent research from the Department of Justice indicates that:
  - 64% of all individuals in local jails report symptoms of mental illness;
  - 74% of those with mental illness met criteria for substance abuse or dependency.

- *Mental Health Court Defendants:*
  The City of Seattle Municipal Mental Health Court and King County District Mental Health Court order an average of 48 competency evaluations combined each month. In January and February 2008, there were 26 defendants whose Mental Health Court cases were dismissed after being found not competent (equivalent to about 25% of the ordered evaluations which projects to approximately 150 defendants per year). These defendants have significant King County jail

booking histories, ranging from five to over 100 bookings per individual (lifetime). Seattle Municipal Mental Health Court data indicate that 70% of the defendants found not competent are homeless and 85% have co-occurring chemical dependency problems. The data reveal that six percent of Seattle Municipal Mental Health Court defendants are veterans and another 31% have unknown status.

Additionally, incarceration often results in loss of housing and benefits, separation from treatment resources, disenfranchisement from family and natural supports, and may result in a criminal history that disqualifies individuals for future housing. Frequent users of publicly funded services are often involved in several systems of care such as behavioral health, social services, criminal justice, and housing, in addition to the health care system. Repeated visits to jails, courts, emergency rooms, and hospitals result in inflated expenses, often absorbed by public systems, which drive up costs.

- *Local Needs Assessment:*
  A local needs assessment is necessary and proposed to determine service need for the target populations, particularly the first target population. Veterans and non-veterans will be referred directly from mental health courts in King County. Individuals are booked by law enforcement and seen in a local court. Anyone involved in the court process (judge, prosecuting attorney, defense attorney) can identify competency as an issue. Most often, the defense attorney raises the issue and the court orders an evaluation to determine if the defendant is able to understand the alleged charges and assist in her/his defense.[1] A needs assessment will be conducted of a sample of defendants whose case is dismissed for these reasons (i.e., the defendant is found not competent).

  It's important to note that only a portion of defendants evaluated for competency are part of the target population for this project. Defendants that are either found competent or incompetent and referred to WSH for commitment evaluation will not be eligible for services. However, it's impossible to know which defendants will be eligible until the court makes a final determination.

Example: Seattle Municipal Mental Health Court: At Seattle Municipal Court, competency is ordered from any and all courtrooms, not just Mental Health Court. The next hearing for that defendant (to review the evaluation) is always scheduled in Mental Health Court. The judge orders the competency evaluation to be conducted by forensic psychologist evaluators from WSH, the entity legally required to complete the evaluation. The "speedy trial" time frame is "tolled" pending the outcome of the ordered evaluation. The court faxes the competency evaluation order to WSH. WSH doctors most often complete these evaluations while the defendant waits in jail (typically, around 10 days). Once the evaluation is complete, the doctor faxes the evaluation report to the court and a date is set to review the report in mental health court.

At the competency evaluation hearing, the defendant appears in court while the judge and attorneys review the competency evaluation report. If the court finds the defendant to be competent, then the case proceeds normally. If so, the defendant can opt in to the Mental Health Court or can elect for the case to be handled in "mainstream" court.

If the court finds that the defendant is not competent, the prosecuting attorney advises the court if the individual meets the statutory criteria for competency restoration. If the defendant does meet the restoration criteria, s/he is ordered to WSH to have competency restored. The court schedules a

[1] The two prongs for legal competence are whether the defendant (a) understands the nature of the offense s/he is charged with, and (b) can assist the defense attorney in preparing/ providing a defense to the offense.

competency restoration hearing 29 days out. The defendant remains in custody, pending transport to WSH by the jail; the hospital coordinates transport based on available bed space, which can take a few days to a few weeks, depending on the WSH census. If competency is restored, the case proceeds normally.

If the defendant does **not** meet the competency restoration criteria, then the underlying case is dismissed and the court refers her/him to the King County Designated Mental Health Professionals to determine if the individual meets the criteria for an involuntary commitment under RCW 71.05.[2] The statute authorizes the jail to continue detention of the individual for up to 72 hours for the RCW 71.05 evaluation. If the criminal case is dismissed and the defendant has been found to be legally not competent but not detainable under RCW 71.05, then all legal involvement ceases resulting in no dedicated supervision or monitoring and no access to Mental Health Court resources or supports, including housing. This project seeks to address the housing and services needs of this target population in addition to eligible veterans referred by the VRS project.

5. Total Dollars Available

There is $500,000 total per year available, $150,000 from the Veterans Levy and $350,000 from the Human Services Levy. Of the total amount, $100,000 per year, $30,000 from the Veterans Levy and $70,000 from the Human Services Levy, is earmarked for a separately approved procurement plan in this activity called the Forensic Assertive Community Treatment (FACT) program. The FACT program used $50,000 in 2007 and will be utilizing $112,500 per year, $33,750 from Veterans Levy and $78,750 from Human Services Levy, from 2008 through 2011 based on a prorated carry-over amount of $50,000 from 2007.

The remaining $400,000 per year, $120,000 from the Veterans Levy and $280,000 from the Human Services Levy, is earmarked for King County CJI Housing/Services, which this procurement plan proposes be allocated to the FISH Project. None of these funds were spent in 2007 and $20,000 will be spent for start-up in 2008 pending approval of this procurement plan. A balance of $780,000 in carry-over funds from 2007-2008 will be applied to the FISH Project in 2009-2011 in addition to the base budget of $400,000 per year.

Original Budget of Levy Funds for Activity 2.5		
	2007 Levy Funds	**2008-2011 Per Year Levy Funds**
FACT Program	$100,000 Actual Spent: $50,000	$100,000
King County CJI Housing/Services	$400,000 Actual Spent: $0	$400,000
TOTAL	**$500,000**	**$500,000**

Revised Budget of Levy Funds for Activity 2.5		
	2007 Levy Funds	**2008-2011 Per Year Levy Funds**
FACT Program	$50,000	$112,500
FISH Project	$0	$500,000
TOTAL	**$50,000**	**$612,500**

Of these amounts, 70% comes from the Human Services Levy and 30% from the Veterans Levy.

[2] The legal threshold is danger to self or others, or grave disability.

Funds Available by Individual Levy, 2008-2011	
	Annualized, 2008-2011
Veterans Levy:	$150,000
Prorated Carry-over (2007) for FACT Program	$3,750
FACT Program Allocation	($33,750)
Subtotal Veterans Levy	**$120,000**
Human Services Levy:	$350,000
Prorated Carry-over (2007) for FACT Program	$8,750
FACT Program Allocation	($78,750)
Subtotal Human Services Levy	**$280,000**
TOTAL	**$400,000**
	From 2007
+ Carry-over from King County CJI Housing/Services	$400,000

This procurement plan proposes that unspent funds in the amounts of $400,000 from 2007 plus $380,000 from 2008, for a total of $780,000, will be carried forward and divided over the remaining three years of the levy, adding $200,000 in 2009 and $290,000 in 2010-2011 to the base allocation of $400,000/year. Any unused start-up funds in 2008 will be carried over to 2009.

Forensic Intensive Supportive Housing Project Budget			
Total Levy Funds Proposed, 2008-2011			
	2008 Funds	2009 Funds + Carry-Over	Annualized Funds + Carry-Over, 2010-2011
Veterans Levy	$500 (Procurements)	$180,000	$207,000
Human Services Levy	$19,500 (Project Start-up)	$420,000	$483,000
Annual Levy Funding	**$20,000**	**$600,000**	**$690,000**

6. Geographic Coverage

King County

7. Evidence-Based or Best Practice Information

There are several evidence-based best or promising practice programs that are pertinent, some or all of which will be utilized in this procurement plan. The following is a description of those program components.

- **Housing Panel Matrix.** An expert housing panel presented a framework for housing model dimensions which include the "umbrella" housing approach (i.e., housing first vs. housing ready), the service-related approach (low demand vs. high demand), the programmatic model (reentry vs. non-reentry), length of stay (transitional vs. permanent), and the configuration (single-site, scattered site and clustered scattered-site).[3]

[3] *Principles and Practice in Housing for Persons with Mental Illness Who Have Had Contact with the Justice System.* CMHS National GAINS Center Evidenced-Based Practice for Justice-Involved Individuals: Housing Expert Panel Meeting, June 1, 2005.

- **Pathways' Housing First.**[4] The Pathways' Housing First program specifically outlines outcomes related to 1) housing stability, 2) consumer choice in housing, 3) cost of supportive housing and services, and 4) the use of support services. These items address housing and support related outcomes, but criminal justice related outcomes also need specific attention. In addition, the availability of the appropriate level of support and intensive outreach and engagement services is vital for longevity of housing stability for the severely mentally ill and substance abusing populations.

- **The APIC Model.** The APIC Model is a best practice approach necessary to address reentry of offenders back into the community. Housing alone will not address all the barriers and challenges the criminal justice involved population faces upon release from jail. The APIC Model consists of the following critical elements:
  - **Assess** the offender-client's clinical and social needs, and public safety risks.
  - **Plan** for the treatment and services required to address the offender-client's needs.
  - **Identify** required community and correctional programs responsible for post-release services.
  - **Coordinate** the transition plan to ensure implementation and avoid gaps in care with community-based services.[5]

- **Co-Occurring Disorders (COD) Treatment.** King County RSN data show that almost half of the 7,200 severely and persistently mentally ill clients served between 1993 and 1998 in King County had a co-occurring substance abuse disorder and one-fifth were homeless at least once during the study period.[6] Treatment services should be co-located and based on the principle that both disorders are primary. Within a housing context, it is especially vital to provide comprehensive and integrated services for the justice involved COD population. Some of the appropriate clinical interventions and effective evidence-based practices for COD populations include motivational, psychopharmacological, and behavioral interventions. Evidence-based programs include Integrated Dual Disorders Treatment[7] and Comprehensive, Continuous, and Integrated System of Care[8].

- **Post Traumatic Stress Disorder (PTSD).** PTSD treatment should be provided for veterans with psychological trauma and non-veterans who've been through a traumatic event and are dealing with PTSD. The prevalence of PTSD is significantly higher in the targeted homeless veterans and non-veterans to be served in the project, with rates ranging from 40 to 80 percent, compared to 8% of the general population in the U.S. The presentation of PTSD in these subgroups is more complex and difficult to address. Substance abuse is a significant variable but it is typical to find other axis one diagnoses such as depression, anxiety, panic, and even psychosis in conjunction with PTSD. Moreover, Complex PTSD may be pervasive in this population as many live traumagenic lives. The United States Department of Veteran Affairs, National Center for PTSD, publishes many manuals and guides for clinicians for addressing PTSD.[9]

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[4] Referenced in SAMHSA National Registry of Evidence-Based Programs and Practices

[5] Osher, F., Steadman, H.J., Barr, H. (2002). *A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-Occurring Disorders: The APIC Model.* Delmar, NY: CMHS National GAINS Center.

[6] March 7, 2007 correspondence with Gary Cuddeback, Ph.D., regarding the University of North Carolina at Chapel Hill study of King County RSN data

[7] SAMHSA's Co-Occurring Center for Excellence Overview Paper 5*: Understanding Evidence-Based Practices for Co-Occurring Disorders.*

[8] Developed by Kenneth Minkoff, M.D. and referenced in SAMSHA's Report to Congress on Co-occurring Disorders (2002)

[9] Refer to The National Center for PTSD website at http://www.ncptsd.org/topics/health.html

- **Paraprofessional Peer Counselor/Forensic Peer Specialist.**[10] Peer specialist services will be available to project participants. Forensic peer support specialists are trained peer staff who are in recovery from mental illness and have past involvement with the criminal justice system including incarceration. The forensic peer specialist may work with clients in groups or individually, however, they will not provide individual counseling services. A forensic peer specialist provides recovery-oriented, direct support to other peers, and assists participants in becoming fully integrated into all aspects of community life. They may assist participants with exploration of transferable skills.

- **Crisis Diversion Center.** SSB-5533, enacted on July 22, 2007, allows local law enforcement officers and prosecutors to divert individuals from the criminal justice system "who have committed non-serious and non-felony crimes, if they are known by the Regional Support Network to suffer from a mental disorder."[11] The individuals can be diverted to a crisis diversion center and held for up to 12 hours. The individuals must be examined by a mental health professional within three hours of arrival, and they must agree to voluntary participation in outpatient treatment. A crisis diversion center for adults will be established in King County, upon Council approval, via the Mental Illness and Drug Dependency (MIDD) Action Plan.[12] The MIDD Action Plan, funded via a 1/10th of 1% sales tax, also includes a strategy to involve significantly more police officers and other first responders in Crisis Intervention Training in King County.

- **Forensic Intensive Case Management.**[13] The Intensive Case Management (ICM) was designed for persons with severe mental illness who are either high service users or not using traditional mental health services at all. The ICM model incorporates a "full support philosophy" and uses a multidisciplinary team approach. It involves assertive outreach, assessment of consumer need, and negotiation and coordination of care. It combines the principles of case management with a low staff-to-consumer ratio.[14] The Forensic ICM team integrates services and coordinates with the courts, law enforcement, and probation and/or the Department of Corrections as appropriate. The team encourages family involvement, where possible, and natural supports. It provides 24-hour crisis services. Active Forensic ICM caseloads are limited to 15 persons per case manager.

- **Assertive Community Treatment (ACT).** ACT is a service-delivery model that provides comprehensive, community-based treatment to people with serious and persistent mental illnesses. ACT is not a linkage or brokerage program that connects individuals to mental health, housing, or human services agencies. Rather, it provides highly individualized services directly to consumers. ACT recipients receive the multidisciplinary 24/7 staffing of a psychiatric unit, but within the comfort of their own home and community. ACT team members are trained in the

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[10] Davidson, L., Ph.D., Rowe. M. Ph.D. (2008*). Peer Support within Criminal Justice Settings: The Role of the Forensic Peer Specialists.* Delmar, NY: CMHS National GAINS Center, May 2008.
[11] Strode, Anne D. (2008). *Draft Final Report: Implementation of SSB-5533 in Washington State Counties & Cities.* Washington Institute for Mental Health Research and Training, Washington State University-Spokane, March 2008. Refer to report at http://mhtransformation.wa.gov/pdf/mhtg/SSB-5533Report.pdf.
[12] Refer to strategies #10a and #10b of the Mental Illness and Drug Dependency Action Plan: http://www.metrokc.gov/dchs/mhd/salestax/12Strategies.pdf.
[13] Addy, J., Mundil, K., Parker, T., Talbott, P. (2008). *Intensive Case Management for Behavioral Health Jail Diversion: The Lancaster County, Nebraska Approach*. American Jails, January/February 2008
[14] Meyer, Piper S., Ph.D. and Morrissey, Joseph P., Ph.D. (2007). *A Comparison of Assertive Community Treatment and Intensive Case Management for Patients in Rural Areas, Psychiatric Services.* American Psychiatric Association: 58:121-127, January 2007.

areas of psychiatry, social work, nursing, substance abuse, and vocational rehabilitation.[15] Active ACT caseloads are limited to 10 persons per case manager.

The Forensic ICM and/or ACT model is the likely preferred program model(s) for the FISH Project to be determined via the local needs assessment.

8. Program Strategy Description

Veteran's and Human Services Levy funds are proposed to be utilized to provide supportive housing for the target populations using a Housing First approach. Procurement and startup costs are $20,000 in 2008. The program service costs in 2009 are $660,000 of which approximately $60,000 will be coming form mental health and chemical dependency treatment funds. The remaining $600,000 is requested from the Veterans and Human Services Levy funds. The program service costs are $1,050,000 per year once the project is fully implemented in 2010 and 2011. Approximately $360,000 will be coming from mental health and chemical dependency treatment funds. The remaining $690,000 is requested from the Veteran's and Human Services Levy funds.

Phase 1, Needs Assessment of First Target Population. The King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) will conduct a needs assessment of the first target population consisting of homeless veterans and non-veterans with mental illness who are involved with the King County Criminal Justice System, placed on a mental health court calendar in King County, and subsequently found incompetent due to severe psychiatric impairment. Phase 1 will consist of reviewing a random sample of "Dismiss and Detain" records on file through the MHCADSD Crisis and Commitment Services section. Dismiss and Detain documentation is filed in response to requests from the mental health court to the King County Designated Mental Health Professionals to determine if a defendant meets the criteria for an involuntary commitment under RCW 71.05.

MHCADSD staff will review approximately 24 Dismiss and Detain records filed during the period of January to June, 2008 in order to ascertain the appropriate array of housing and support services needs for the target population studied. A random sample will be selected for review from each month of the six-month period, for an average of four records per month. Each record, which includes background information, diagnostics, investigation notes and findings/determinations, will be reviewed using a comprehensive assessment tool covering the following domains:

1) Psychiatric history, mental status, diagnosis, and psychotropic medications
2) Trauma history
3) Physical health
4) Substance abuse
5) Education and employment
6) Social development and functioning
7) Current criminal justice involvement and history
8) Housing status/homelessness
9) Activities of daily living
10) Family structure and relationships
11) Veterans status (if documented)
12) Benefits status and current services enrollment

Assessed housing and services needs, including trauma services, will be matched with the best and promising practices listed in section 7 above, and service gaps and capacity needs (for veterans and

[15] Cited from National Alliance on Mental Illness (NAMI) website at http://www.nami.org

non-veterans) will be identified. The results of the needs assessment, service gaps, and capacity needs will be compiled for inclusion in a Request for Proposals (RFP) to be issued in October 2008. No Levy funds are requested for Phase 1, as MHCADSD will provide in-kind staffing resources, estimated at 30 total staff hours, to complete the needs assessment by August 8, 2008. The results of the needs assessment are provided via an addendum to the procurement plan.

For both target populations, the project will be fully implemented via a competitive RFP process.

Phase 2, Project Implementation. Phase 2 will consist of start-up and full implementation of the FISH Project to secure housing options and implement program services based on the needs assessment results from Phase 1. The FISH Project will introduce new programs or enhance/expand existing programs to accommodate the referred populations identified in this procurement plan. Specifically, the County will purchase sufficient housing capacity, including permanent housing, and intensive supportive services for up to 60 eligible clients. The intensive supportive services purchased under this procurement plan are intended to address service gaps and capacity expansion needs that can not be fully covered under the existing mental health and chemical dependency service systems in King County.

The County will also purchase a minimum of 1.0 FTE liaison or "boundary spanner" position to provide a single point of contact for eligible referrals. Assistance shall be provided with transportation to the services site, triage, screening and assessment services, assistance in applying for publicly funded benefits, and linkage to treatment and crisis services, if needed. Other staff positions, including case managers, peer specialists and other team members, will be required as indicated via the needs assessment results and proposed via the RFP process.

The County seeks to contract with a single agency that provides housing, treatment, and supportive services or the lead agency of a partnership (via subcontract relationships) comprised of one or more housing providers and one or more service providers.

The project will consist of the following components:

- **Initial Engagement and Outreach**
  Some, if not most, of the target populations will be resistant to services. Initial engagement and outreach may take weeks to motivate the client to agree to services, housing, and medications monitoring. In a few cases, the engagement phase may take months but will be limited to no more than six months duration. Outreach efforts will continue until the client agrees to services or the engagement phase of six months has expired.

- **Transport or Escort to the Service Site**
  Once the client agrees to services, the safety of the client shall be assured while s/he is transported to the service site. Eligible clients will be transported or escorted directly from jail upon release.

- **Triage, Screening and Assessment**
  Initial triage and screening, including screening for PTSD, and assessment of clinical and support needs will be provided within three business days of referral, and is especially important for participants with COD. An assessment tool shall be used to prioritize housing placement with the most vulnerable persons being housed first.

- **Respite with 24-hour Monitoring**
  Mental health and/or crisis respite and monitoring services will be provided to eligible clients, for those who are in immediate need of shelter and mental health services, for no longer than seven business days. At that point, clients will be moved to permanent supportive housing or other housing options if placed on a wait list (see previous item on screening and assessment).

- **Assistance in Applying for Benefits**
  Immediate application to the WA State Department of Social and Health Services (DSHS) for entitlements and other publicly funded benefits will be provided including a psychological assessment if needed to meet benefit threshold requirements. All application requirements will be done within three business days of initial triage and screening.

- **Treatment and Crisis Response**
  Refer to evidence-based best practices above. If a greater level and intensity of services is needed than is available though the King County Regional Support Network (RSN), then a combination of services will be implemented. Enhanced access to health care, prescriber, and trauma services shall be available to the clients served in this project. Funding via this proposal shall be used to provide services that are not covered through the RSN.

- **Permanent Housing and Supports**
  The project will use a Housing First approach to engage and rapidly house frequent institutional users who are homeless. A range of housing models and options will be used to accommodate and support individual stabilization and recovery. The referral process will consist of low barrier access and limited exclusionary criteria to engage and house the identified populations who have a history of long-term homelessness and recidivism. Clients will be prioritized for permanent housing (or temporary housing if awaiting permanent housing) with the most vulnerable clients being permanently housed first. The housing facility(s) shall have 24-hour housing management staff including front desk coverage, guest monitoring and housing assistance.

  On-site or off-site services will include behavioral health and employment services. The rules and structure of the residential program shall be designed to complement the provision of individual client support services, including housing stabilization, to create a comprehensive rather than fragmented supportive housing model. Long-term supports shall include intensive case management and/or assertive community treatment (based on the results of the local needs assessment), and peer support. Peer support will be provided by a former or current consumer of mental health services who is trained in the Wellness Recovery Action Plan; ideally, someone with experience in the criminal justice system (forensic peer specialist). Peer support specialists may work with clients in groups or individually; however, they shall not provide individual counseling services. Potential candidates shall receive appropriate training prior to working with clients.

The project will identify liaison staff with the responsibility to receive referrals, provide linkage to housing and coordinate with both the mental health courts and VRS program staff. The liaison/boundary spanner position(s) is vital in order to provide a single point of contact for the target populations to ensure that the provider agency(s) can appropriately identify their capacity for timely acceptance of referrals, provide individualized services and supports and participate in follow-up and monitoring activities. Because the participants will be justice involved, the liaison position(s) is also important to assist the client in negotiating the legal system and possible court or DOC supervision requirements.

Some clients will be currently enrolled in the RSN and will need assistance in getting reconnected to services, if appropriate. The liaison/boundary spanner will be responsible for assuring that these clients are reconnected to services and will monitor them until they are reengaged in services or contact is lost.

Service data will be submitted to the County per MHCADSD policies and procedures.

Referrals from Mental Health Court

The degree of expertise and familiarity that community mental health case managers have about the criminal justice system and proceedings related to competency is minimal; thus an "expert" liaison/boundary spanner to coordinate and communicate between the respective systems is necessary and will improve the treatment connections and outcomes for these individuals. For eligible defendants, the court will fax a copy of the competency evaluation order to the appropriate liaison, with a signed release of confidential information, at the designated provider agency. The liaison will check the defendant's mental health services history through the King County Extended Client Lookup System (ECLS). There are two benefits to informing the liaison of any pending competency evaluation:

1. The liaison can develop a relationship with the defendant prior to release from jail and can initiate expedited access to benefits, reconnection to mental health and other services, and access to housing as well as identify if the defendant is on the King County High Utilizer list.
2. The liaison can complete screening and assessment on a larger defendant pool, which will inform a more targeted service plan for eligible clients.

Upon determination of incompetence and referral to local resources, the liaison/boundary spanner will arrange for transport from jail upon release to housing and/or other services. At this point, the client will be triaged, screened (including screening for trauma/PTSD), and assessed at the service site. The client may be identified in the High Utilizer database being developed by King County. This database will eventually facilitate coordinated entry into existing and new housing, services and supports.

As soon as an order for competency is entered, the liaison will be provided a copy of that order, and identifying information for the defendant, including the mental health treatment history, as included in the county's mental health database (ECLS), and the criminal history to review criminal charges and dispositions in other jurisdictions. The liaison will review the ECLS and make contact with the defendant to obtain additional and current treatment history, as well as to learn about housing, medications, and other court matters.

This proposal, a two-track model, will service the misdemeanor criminal justice population who present competency issues and are ultimately found to be "not competent to proceed" and will work as follows:

Track 1: For the cohort of defendants who are currently enrolled and tiered in the county mental health system, the liaison will contact the case manager of record and discuss the defendant's engagement, involvement, and compliance with the treatment plan and with the reported housing resource. The liaison will advise the case manager of the ordered competency, underlying criminal charges, next court date, facilitate the case manager connecting with the defendant in person, pending the next court date, and review the service needs of the defendant. While this cohort will likely have a case manager, the introduction of the expert liaison will significantly improve coordination with the court.

If this cohort is found to be **not** competent to proceed, the early engagement with the case manger of record will greatly enhance the resource "bridge" from custody to community based services, and will include accessing housing, treatment, PTSD services (if needed), medication and other service resources.

Track 2: For the cohort of defendants who are currently not enrolled or tiered in the county mental health system, the liaison will interview the defendant, assess the treatment, medication and housing needs, and initiate a treatment program to support the defendant. Using the Recovery Model principles, the liaison will work with the defendant to develop and support treatment goals of reducing bookings into jail and increasing treatment episodes with a provider agency. The liaison will explore and initiate the application for public benefits, will explore "next day appointment" options with a community mental health provider, will review housing options, and will develop a release/treatment plan that includes a "bridge" to services.

For the cohort of defendants found to be **not** competent to proceed, the early assessment and screening for eligibility and services will enhance the resource bridge from custody to community based services, to include housing, treatment, medication and other service resources. Appropriate services and/or linkages will be made based on need and eligibility. Services may include detoxification, assistance with applying for publicly funded benefits, chemical dependency treatment, mental health services, and other services as needed. The client will be prioritized for permanent housing (or temporary housing if awaiting permanent housing) with the most vulnerable clients being permanently housed first.

Referrals from Veterans Reintegration Services (VRS)
A case manager(s) assigned to serve veterans will not work with non-veterans. VRS receives referrals via jail kite (self-referral) or from social workers, probation officers, criminal justice liaisons, release planners, DOC community corrections officers, and public defenders for inmates incarcerated in any jail within King County. A screening is done to collect booking and charge information, sentencing information, and determine eligibility for Veterans benefits. If ineligible, then the inmate is referred to mainstream community-based services upon release.

If eligible for Veterans benefits, then a full assessment is conducted including background and family information, criminal history, physical and mental condition, housing status, employability, education, and job skills. A clinical assessment is conducted, if indicated, including chemical dependency and mental health/trauma. The assessment results are used to develop a case plan, consisting of a treatment plan and support services plan, for each eligible inmate assessed. With a signed release of confidential information, the case plan is shared with the court along with a letter advocating release to treatment and other services including housing options.

Upon release, eligible veterans may be referred for detoxification or Intensive Inpatient chemical dependency treatment followed by Outpatient treatment and aftercare. Transportation and financial assistance are provided, if needed. Assistance with obtaining work clothes and tools is provided for those who are employment ready. Assistance with job search, vocational counseling, job training and education, apprenticeship programs and resume assistance are available.

Eligible veterans with mental health issues are assessed for PTSD and, if warranted, referred to PTSD services. Veterans with other mental health disorders may be referred to programs available through the county, state or federal Veterans programs or through the King County Regional Support Network. Homeless veterans with serious and persistent mental illness will be targeted for the FISH Project described in this procurement plan.

For clients found eligible for the FISH Project, a liaison/boundary spanner will arrange for transport from jail upon release to housing and other services. At this point, the veteran will be triaged, screened, and assessed at the service site. The veteran may be identified in the High Utilizer database being developed by King County. The liaison will review mental health services information in ECLS and make contact with the veteran to obtain additional and current treatment history, as well as to learn about medications and other court matters. The veteran will be prioritized for permanent housing (or temporary housing if awaiting permanent housing) with the most vulnerable clients being permanently housed first.

For both target populations, a service model(s) shall be implemented based on the needs assessment results obtained during Phase 1. The Forensic ICM and/or ACT model is the likely and preferred program model(s) for the FISH Project.

The Levy boards will be alerted to any significant revisions to the program model once services are fully implemented.

9. Disproportionality Reduction Strategy

Countless prevalence studies have established that persons of color are overrepresented in jail populations in proportion to their numbers in the general population at large. The awarded program will contribute to a reduction in disproportionality in the local jails by reducing barriers to accessing and maintaining housing. Disproportionality will be addressed at the individual and system levels, within each participant's plan, supportive housing and other services, through special population consultations and the use of peer support.

The process and outcomes evaluation will track the number of individuals referred and accepted into the FISH Project by race/ethnicity, in comparison with racial/ethnic profiles of jail populations in King County, and review the course of their participation in the project.

10. Coordination/Partnerships

Strong coordination already exists with King County Criminal Justice System components. The following agencies that are involved in the King County Criminal Justice Initiatives (CJI) have committed to be involved with the project:

- Auburn Municipal Mental Health Court
- Auburn Police Department (operates a city jail)
- Auburn Probation Department
- Enumclaw Police Department (operates a city jail)
- Issaquah Police Department (operates a city jail)
- Kent Police Department (operates a city jail)
- King County Department of Adult and Juvenile Detention
- King County District Mental Health Court
- King County Office of the Public Defender
- King County Prosecuting Attorney's Office
- King County Sheriff's Office
- King County Veterans Program
- Kirkland Police Department (operates a city jail)
- Renton Police Department (operates a city jail)
- Seattle Municipal Mental Health Court
- Seattle Police Department (operates a Crisis Intervention Team)
- Washington State Department of Corrections
- Washington State Department of Veterans Affairs

The six suburban municipalities listed above (specifically, their municipal courts) routinely work with the VRS project to link offender-clients to appropriate veterans services, if eligible. This proposal will provide timely access to permanent supportive housing for homeless, seriously mentally ill veterans identified in city jails within King County, in addition to those identified in the King County Jail, Seattle or Kent Divisions.

Seattle Municipal Mental Health Court and King County District Mental Health Court have been partners in developing this project and strongly support implementing programs targeted toward these vulnerable individuals. Both courts have already devoted staff time toward the project.

11. Timeline

The needs assessment will be conducted by MHCADSD beginning immediately upon approval of the Levy boards. Data will be collected and collated by August 8, 2008 in preparation for the RFP. The RFP will be developed and issued no later than October 1st, 2008 seeking a provider for the Forensic Intensive Supportive Housing Project. The respondents to the RFP must be licensed/certified to provide publicly funded mental health and chemical dependency services in the State of Washington, must have a service office within King County, and must own or have the ability to secure appropriate housing options including long-term or permanent housing within King County. The County seeks to contract with a single agency that provides housing, treatment, and supportive services or the lead agency of a partnership (via subcontract relationships) comprised of one or more housing providers and one or more service providers.

Proposal Schedule:

October 1, 2008	RFP released
October 7, 2008	Bidders Conference
October 8, 2008	Written questions due
November 12, 2008	RFP solicitation period closes
November 26, 2008	Evaluation of written proposals
December 1, 2008	Interviews, if conducted
December 2, 2008	Final results released
December 3, 2008	Contract negotiations begin
December 2008	Contract developed
December 2008	Contract signed and executed

Program startup (staff recruitment only) will be initiated in December 2008 and the program will begin serving consumers during the month of January 2009.

12. Funding/Resource Leverage

Forensic Intensive Supportive Housing Project Budget			
Total Funds Proposed, 2008-2011			
	2008 Funds	2009 Funds + Carry-Over	Annualized Funds + Carry-Over, 2010-2011
Medicaid and GAU funds from MHCADSD mental health and chemical dependency treatment resources	$0	$60,000	$360,000
Proposed to come from King Co. Veteran's and Human Services Levy	$20,000	$600,000	$690,000

Total Services Funding	**$20,000**	**$660,000**	**$1,050,000**

13. Dismantling Systemic/Structural Racism Strategy

Dismantling racism will be addressed at the individual and system levels, within each participant's plan, via supportive housing and other services, and via reduced recidivism. Given that fair housing laws do not allow housing providers to target permanent housing to households or individuals of a particular race, ethnicity, gender, etc., racism will be addressed by emphasizing and ensuring equal and fair access to housing and culturally competent provision of services. Culturally competent outreach and engagement will maintain the diversity intrinsic to the eligible populations.

14. Cultural Competency

The project will not discriminate on the grounds of age, race, color, creed, religion, sex, handicap, national origin, marital status, parental status, sexual orientation, the presence of any sensory, mental or physical handicap, or the use of a trained dog guide by a blind or deaf person. MHCADSD requires that contracted agencies demonstrate cultural competency through a variety of strategies and will have the same expectations of the FISH Project provider. The agencies must provide program information and consumer rights in commonly used languages in King County besides English. They must arrange for interpreter services for program participants as needed. Additionally, agencies must seek cultural or special population consultations for those individuals from cultural or ethnic minority populations. Demonstrated cultural competency will include the Veterans culture and staff will be trained on a PTSD approach in order to better serve veterans (and non-veterans) who've been through a traumatic event and are dealing with PTSD.

15. Alignment within and across systems

The King County CJI will be actively involved in monitoring the implementation of the awarded program. Additionally, the King County CJI will continue to work closely with the mental health courts, the Washington State Department of Veterans Affairs, and the King County Veterans Program to coordinate referrals to the FISH Project.

16. Improvement in Access to Services

The housing first approach is designed to promote participant success by providing easily accessible services for health and housing stability, residential support, crisis intervention, and other supportive services. In all interactions, the participant's right to make choices based on perceived needs and desires will be respected, even if the choices being made by a participant seem non-productive to staff. All participants will have readily available case management to assist with daily living skills, appointments, legal issues, medications, and co-occurring disorder concerns. The participant shall receive regular case reviews on housing needs and issues. At a minimum, there will be focus on assistance with:

- Basic needs. The first responsibility is to ensure access to food, clothing, medical care and income. A flex fund will be set up to cover food and clothing needs, and transportation costs for accessing and applying for publicly funded benefits through DSHS.
- Accessing treatment and crisis services. All participants will have access to professional assessment and treatment or crisis services for their presenting problems.
- Engaging in meaningful activity. Each participant should be exposed to activities he or she believes to be meaningful and beneficial (e.g. recreation, volunteer activity, day programs, and employment and education services).

17. Provider Selection/Contracting Process

Please see Timeline section (#11) above.

18. Outcomes (including disproportionality reduction outcomes)

- Phase 1: The outcome of this phase is a completed needs assessment with the following information:
  - Housing needs
  - Trauma service needs
  - Other service needs
  - Services gaps
  - Capacity gaps

  Needs will be identified for veterans and non-veterans. The results of Phase 1 will drive the specific details of the programs implemented in Phase 2 and their outcomes.

- Phase 2: Demographic data will be collected to ensure the programs are serving the intended target populations, facilitating participants toward recovery and self-sufficiency, and to assess impact on disproportionality reduction.

  Outcomes specific to the selected interventions will be added to the evaluation plan after the contracting process is completed. Anticipated outcomes include:

  - Increased access to permanent supportive housing
    - Increased intense supportive housing capacity
    - Increased number of individuals housed
  - Increased housing stability
    - Length of time to get housing
    - Duration in housing
    - Type of housing (respite, transition, permanent)
  - Increased income stability
    - Increased enrollment in benefit programs (Medicaid, VA, other)
    - Increased use of employment services
  - Decreased recidivism
    - Decreased jail days and bookings
    - Increased compliance with court ordered services
  - Increased appropriate clinical interventions to address mental health and/or substance abuse recovery
    - Increased screenings and linkages to services, esp. PTSD
    - Increased completion of treatment plans (CD, MH)
    - Increased use of primary care health services
    - Improved medication management
  - Decreased use of high cost medical services
    - Decreased use of crisis services, detox
    - Decreased unnecessary use of inpatient hospital services, ER services

The populations served and all outcomes will be examined by demographic indicators to ensure that a minimum of 30% of those served are veterans and that similar outcomes are achieved for all race and ethnic groups.

19. Process and Outcome Evaluation

The investment strategy to increase permanent housing with supportive services for Veterans and other persons in need will be evaluated on both process and outcomes by evaluators hired in the DCHS, Community Services Division. We will work with the evaluators to measure the effect of the Levy on process issues such as startup activities, contracting processes, participant engagement and retention, issues that impact disproportionality, collaboration and system level changes that occur, and on the outcomes listed above.

NARRATIVE SUMMARY OF NEEDS ASSESSMENT FINDINGS

1. Study Design Proposed

King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) proposed to complete a review of approximately 24 Dismiss and Detain (D&D) records filed during the period of January to June, 2008 in order to ascertain the appropriate array of housing and support services needs for the target population studied. The proposed review was to include a random sample selected from each month of the six-month study period, for an average of four records per month. Each record, which includes background information, diagnostics, investigation notes, findings and determinations, will be reviewed individually and comprehensively.

2. Study Completed

Jessie Benet, M.A., LMHC, Program Manager in the Criminal Justice Initiatives Project for King County MHCADSD reviewed a total of 26 case files of D&D referrals to the King County Crisis and Commitments Services from King County District Court, City of Seattle Municipal Court and one file from Auburn Municipal Court (referrals were mostly from the Mental Health Court of each jurisdiction). Ms. Benet reviewed only D&D files where the disposition was not to detain and the cases did not meet Involuntary Treatment Act (ITA) criteria per RCW 71.05. In all cases reviewed, the individuals were released from jail to the community.

3. Background

Dismiss and Detain is a referral process to King County Crisis and Commitment Services' Designated Mental Health Professionals (DMHPs) where individuals who have become involved in the criminal justice system are then referred to the civil commitment system. Once an individual is found not competent by the court of jurisdiction and the court or jail determines that the individual needs a referral for RCW 71.05 Involuntary Treatment (ITA), the individual is then held in jail until the DMHP completes an assessment and determines if the individual meets criteria for ITA.

Those who do meet criteria are released on an involuntary hold in an inpatient hospital for evaluation and treatment. Those who do not meet ITA criteria are soon released from jail back to the community because the charges have been dismissed and the legal system no longer has authority to supervise the individual. This is the very population that the current study examines. Our data come from the assessment the DMHP completes along with any collateral information they collect during the process, which often includes forensic evaluations for competency completed by Western State Hospital evaluators as well as previous treatment records.

4. Findings (See Data Summary in Addendum 2)

The study period was January 2008 through June 2008. Of the population described above, a random sample of four to five files from each month was reviewed. In the first six months of 2008 (the study period), Crisis and Commitment Services received 133 D&D cases, which is an average of 22 per month. Domains reviewed include demographic, diagnostic (mental illness and substance use history), housing status, education and employment history, conviction and jail booking history, benefit status and public entitlements, publicly funded treatment history in the King County Regional Support Network services, social functioning and family/natural supports status. Physical health was difficult to ascertain from the records reviewed, although some medical issues associated with chronic

substance abuse were mentioned (e.g., Hepatitis). There was also very little information on activities of daily living.

Subjects consisted of 26 individuals:
- 12% are Veterans;
- Ages range from 19 years to 74 years old;
- 92% have a psychotic mental disorder;
- 92% have co-occurring mental health and substance abuse disorders (COD).

Criminal Activity
- 100% of the cases reviewed involved low-level nuisance crimes.
- The average number of lifetime bookings in a King County jail for the sample was **16.7**.

The majority of the charges involved are misdemeanors such as Unlawful Bus Conduct, Criminal Trespass, Theft (Shoplifting), Obstructing Justice, Disorderly Conduct, etc. These crimes are often due to police not having other options for these individuals because their mental illness is untreated and they are often actively using substances, which can result in assaultive, paranoid and other kinds of behaviors that are extremely difficult to diffuse and stabilize. The effect of co-existing mental illness and substance abuse is profound, especially when trauma histories and homelessness are present to exacerbate the mental health issues - the result is most often a jail booking.

Homelessness
- 77% were homeless at the time of arrest.

Historical homelessness was more difficult to determine based on the information reviewed, but several subjects have been homeless for several years (one individual had been homeless for seven years).

The impact of homelessness on individuals struggling with mental illness and substance abuse is massive and, without housing and intensive treatment supports, this population is often reduced to a lifetime of cycling through the system (criminal justice interface, booked into jail, found not legally competent by the court and then released back to the community without any services or housing). This cycle is a huge cost to every system involved: criminal justice (police, jail, courts, prosecutor, and public defense), State forensic evaluations, County crisis services, emergency services and more. Most, if not all, of the cases reviewed have significant history of utilizing all these systems repeatedly.

Education and Employment
- 90% had dropped out of school between the 10th and 12th grade (a few subsequently earned a GED).
- 50% had not sustained gainful employment in over five years, if ever.

Lack of education and employment is a huge variable in these individuals' lives. Only one individual had completed some college courses and one other had completed some vocational training at a community college. There is clear need for vocational and supportive services among this population in order to help these individuals break the cycle of coming into contact with the legal system due to untreated mental illness, substance abuse and homelessness.

Current Services
- 65% were not enrolled in any mental health services at the time of arrest.
- 27% were enrolled in some form of mainstream community mental health services.

- 2 individuals (8%) were very recently referred to Program of Assertive Community Treatment (PACT) services.

Based on the level of criminal justice involvement and the needs assessment findings, the level of current mainstream services provided is not adequate to stabilize the population to prevent future criminal justice and other emergency and crisis services contact. In addition to housing and housing supports, specialized, intensive and participant-need based services are necessary to adequately address the challenges this population faces. Lower caseloads, more wraparound services (beyond case management) including peer support, and dedicated vocational services are vital components of recovery for this population.

5. Recommendations for Treatment (in addition to Supportive Housing component).

The entire sample meets the need for the service intensity of Forensic Intensive Case Management (FICM), and approximately half would also meet admission criteria for Assertive Community Treatment (ACT) services, which is one of the most intensive services available in a community mental heath setting. However, ACT services are intended for individuals who have extensive history of being psychiatrically hospitalized. The sample of cases studied involves individuals who do not meet criteria for involuntary hospitalization and are released back to the community.

A highly structured FICM model paired with supportive housing is the best fit for this population. Because FICM is a promising practice with some flexibility on defining what components a FICM model includes, some adaptation is recommended to include recovery oriented services necessary to assist this population in both housing stability and treatment engagement. Based on the staffing model below and level of services and housing supports, it is estimated that program capacity will be up to 60 individuals. Some fundamental elements of the recommended FICM service model proposed for the FISH Project include the following:

FICM Services for the FISH Project
(Note: Housing is NOT contingent upon participant participation in services)

Transdisciplinary team approach. The FISH team would not have participants assigned to a single case manager, but the entire team would be responsible to all of the participants in a shared caseload approach. This allows for the entire team to build rapport with each participant in the program and all staff to provide services in coordinated and fluid manner. Although each team member will have their area of expertise (mental health, chemical dependency, vocational services, peer support) and is expected to provide the majority of these types of services, there is also room in the transdisciplinary approach for the team to share roles and cross discipline boundaries in order to provide more integrated and efficient assessments and interventions.

Community-based services. A minimum of 75% of the services the FISH team delivers to the participants shall be community-based and not provider office-based. It is expected that the FISH team provide treatment and support in various other locations including the participants' housing sites and in the community (parks, sober support groups, restaurants, stores, etc.) in order to assertively engage and provide outreach to each participant as appropriate. Helping participants out in the community by role modeling appropriate behavior in various life situations (public transportation, shopping for food and clothing, education and job appointments, etc.) is part of the continuum of support this population requires. It is also important that the FISH team facilitate participants in learning to keep appointments with a provider and access services at the provider site, as they matriculate to more mainstream services when appropriate.

Staffing. The staffing model* recommended for the FISH team is described below:

1. **2.0 Full Time Equivalent (FTE) Bachelor's level mental health case managers** (one of these staff can be a Chemical Dependency Professional (CDP) or CDP Trainee (CDPT).
2. **1.0 FTE Master's Level Mental Health Professional (MHP)** – there must be a minimum of one MHP on the FISH team. Again, this staff person may be dually certified as a CDP/CDPT.
3. **1.0 FTE Master's Level Forensic Boundary Spanner** (see below for further information on this position; experience does not have to be in a social services field).
4. **1.0 FTE Vocational Specialist** providing education and employment services to FISH participants. The provider agency will be expected to be providing vocation services in a supported employment (evidence-based practice) model.
5. **Psychiatric Prescriber** (Psychiatrist or ARNP) with a minimum of 16 hours per week dedicated to the FISH participants.
6. **1.0 FTE Forensic Peer Specialist**. The provider agency may divide this body of work into two half-time peer specialist positions with one being dedicated to the Veteran population in the FISH Project. Because criminal history is a significant barrier to becoming a certified peer specialist in the State of Washington, we do not expect the agency selected to require these staff to become certified, rather, it is more important that the peer specialist mirror the FISH participant population in terms of criminal justice history and can relate to the participants in terms of a history of involvement in the criminal justice system. This staff person will be expected to complete 40 hours of peer counselor training.

*Staff for these positions may fulfill more than one position requirement by being dually certified, for example, in both mental health and chemical dependency service delivery; however, at least one of the staff on the FISH team shall be a CDP/CDPT. Staff positions included in calculating the staff-to-participant ratio are the case managers, vocational specialist and forensic boundary spanner, which gives a total staff to participant ration of 1:15, but please note none of the staff carry an individual caseload as the model prescribes a shared caseload.

The **Forensic Boundary Spanner** position will serve as the liaison between the criminal justice system and the FISH team. This is a unique position in that this staff person will be expected to have mental health/substance abuse expertise and training as well as a depth of knowledge and understanding of how to navigate all aspects of the criminal justice system that potential FISH participants could be involved in. This includes a direct and close relationship with the mental health courts (referral source), other mainstream courts that may be involved in prior cases, probation entities who may have previous oversight or involvement with a FISH participant, King County Jails, municipal jails in King County, Jail Health Services, public defense agencies, prosecutors, police (including Crisis Intervention Teams) and other first responders.

The Forensic Boundary Spanner is responsible to bridge the systems in order to increase communication, coordination and collaboration. The position plays a significant role in one of the overarching goals of the program, which is a reduction of future criminal justice involvement for FISH participants. Supportive housing, substance abuse and vocational services have all been shown in the research literature to have an impact on future criminal justice involvement and these intervention and service strategies are key in the FISH Project, but will not be as effective without the appropriate Forensic Boundary Spanner position to facilitate system understanding and navigation. It's important to have an understanding of the intersection of the criminal justice system with the human services system to support those who are participants of both systems, such as the population identified for the FISH Project. Each system has very different ways of doing business day to day, communicating and measuring success. A boundary spanner will be able to translate and help both

systems assist FISH participants to be successful with treatment and preventing future criminal justice involvement.

Mental health, substance abuse, vocational and peer support services shall be delivered by the FISH team. The FISH team shall be staffed in such a way (as outlined above) that the team is solely responsible to FISH participants only (and not delivering services to, or shared with, other programs within the agency) and will be the sole provider of the bulk of the interventions based on participant need. Exceptions may be allowed for specialized services or based on participant choice (i.e. participant is already working with a specialty provider or wishes to).

Integrated Co-occurring Disorders (COD) treatment. Mental health and substance abuse services shall be delivered in a fully integrated manner to FISH participants with COD, which will be the norm. This necessitates that, from assessment on, the mental heath and substance abuse issues are seen as mutually co-existing conditions and program staff members explore, determine and respond to the effects of two mutually interacting disorders by treating them as co-primary. Evidence-based, integrated COD treatment services based on the Comprehensive, Continuous, and Integrated System of Care model for organizing services for individuals with co-occurring psychiatric and substance-related disorders is recommended.

Assertive Outreach and Engagement. The FISH team shall use a variety of techniques to engage eligible individuals who are difficult to treat. Some of these strategies involve the use of motivational interventions with a focus on facilitating participant autonomy. The FISH team should implement a thoughtful process for identifying the need for assertive engagement, measure the effectiveness of techniques used, and modify the approach when and where necessary to best serve the client.

Peer Support and Wellness Recovery Services. The forensic peer specialist shall serve as part of the FISH team to provide coaching and consultation to participants to promote recovery and self monitoring and direction. The peer specialist shall implement the Wellness Recovery Action Plan (WRAP) or other wellness management strategies with FISH participants and provide ongoing WRAP facilitation and support. The peer specialist shall fully participate as a FISH team member and take part in all activities as well as provide modeling and cross-training for other team members in recovery principles and strategies.

A primary objective of the FICM model for the FISH Project is a focus on working within each participant's current criminal justice context as well as working towards the goal of preventing future criminal justice involvement. In addition to housing, assistance with navigation of the criminal justice system (boundary spanner) and substance abuse treatment (CDP/CDPT) are both key aspects to preventing future criminal justice involvement. In order to promote recovery from mental illness and substance abuse, peer and vocational specialists will provide the much needed bridge to managing mental illness, finding natural supports and taking on new roles in our communities.

PROCUREMENT PLAN
ADDENDUM 2
Veterans and Human Services Levy: 2.5
Forensic Intensive Supportive Housing Project

Data Summary of Needs Assessment (n=26)

Demographics

Gender:	Male	20	77%
	Female	6	23%
Ethnicity:	Caucasian	15	58%
	African American	9	35%
	Asian/Pacific Is.	2	8%

Veterans	3	12%

Housing Status

Homeless:		Transitional:		Permanent:	
20	77%	1	4%	5*	19%

*2 very recently referred to PACT and are in PACT Housing
*2 are living at the DESC Morrison (supportive housing)
*1 lives with a family member

COD (Co-Occuring Substance Abuse and Mental Health Disorder)

COD:	24	92%
MH only:	2	8%

Mental Health Diagnoses

Psychotic Disorder:	24	92%
Other (mood, anxiety):	2	8%

Enrolled In Current Services

None:	HOST:	3A:	3B:	PACT*:
17	3	3	1	2
65%	12%	12%	4%	8%

*Very recent referrals to PACT